Poetic Resistance: Juxtaposing Personal and Professional Discursive Constructions in a Practice Context

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Within many allied health professions in Canada, there has been a growing emphasis on the language and methods of science as health professions seek to justify their services in the current health care climate. This is evident in the languages of accountability and evidence-based practice (Sackett, 1997) used by health professions to prove their efficacy through the adoption of discourses of science, objectivity and measurement.

As an educator involved in health professional education, I reflect in this paper on a personal experience from my previous work as an occupational therapist to reveal the type of tensions that may be experienced by practitioners and clients when actions are cast solely within the realm of a dominant discourse. I suggest that reflection on practice rooted in poetic form can illuminate such tensions, foreground previously silenced experiences, create new interpretations of health care practitioners' life worlds, and inform thoughtful decisions about the design of curricula in the health professions. Understanding gained through poetic reflection offers insight into the nature of tensions experienced by practitioners whose work is informed by discursive constructions within professional settings.

The dominant discourse: Questioning the text

The adoption of discourses that highlight the language of objectivity in occupational therapy (and other health and human service professions) is consistent with Harris' (1992) observation of many female-intensive profes-

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sions that attempt to achieve status through a rejection of a service-oriented, relational emphasis and through the adoption of the language of objectivity and science. From an educational perspective, Madeline Grumet (1988) has noted problematic implications of such a rejection. In the context of schooling, she writes that teachers "have delivered the children over to language, rules and relations" that are "increasingly mechanized and impersonal" (p. 56). This is a tension that Van Amburg (1991) and Benner (2000) identify in health care environments. They link Western society's use of the language of Cartesian dualism, "which ties us to an epistemological, or knowledge-based paradigm of interpreting our experiences by disengaging subject from object" (Van Amburg, 1991, p. 186) to disengaged relationships in health care practice. As Benner (2000) writes:

> With the success of Cartesian medicine, the body came increasingly to be understood…as the physiological mechanical body composed of organ systems, tissues, cells and biochemistry. Disease became explainable by external pathogens, or an interaction between external causes, and internal resistance forces and functions. (p. 6)

In health care settings this Cartesian language informs a widespread call for evidence-based practice grounded in epistemic assumptions that value the separation of the object of the body from the subject of the person, and which emphasizes the first. Many health professions value "objectivity" as a gold standard in clinical practice, and emphasize "objectivity" in their codes of ethics (Van Amburg, 1997). As Van Amburg (1997) indicates:

> Our socially accepted commitment to dualism is reflected in our appeal to scientific objectivity and its mandate to remove subjective interference from objective observation. This disengaged perspective is believed to remove the contaminating effect of personal influence on scientific experiments. (p. 186)

Interestingly, the attributes of a professional identified by Benveniste (1987) emphasize that a professional: applies technical knowledge, has completed higher levels of education, demonstrates competence in order to be admitted to and remain in the profession, is bound by a code of ethics, is a member of a professional association which supports his/her practice, and feels responsible to the public he/she serves. Thus, the official discourses that professions value and emphasize have incredible power to influence how professionals behave in practice. Given the emphasis on objectivity and science, health professionals "are rewarded for efficiency, technical skill, and measurable results, while their concern, attentiveness, and human engagement go unnoticed within their professional organizations and institutions" (Phillips, 1994, p. 1). Therefore, ways of knowing that value care (Noddings, 1995), nurturance (Grumet, 1988), relationship (Belenky, Clinchy, Goldberger & Tarule, 1997) and situated knowledge (Haraway, 1991) are frequently given

less attention and legitimacy in professional practice. This creates a tension whereby practitioners face an implicit pressure to attend most seriously to professional ideals of objectivity and measurable results, despite frequently being drawn to a career in the health professions out of relational ideals and a desire to "care" for the other.

One irony, as Donald Schön (1983) has noted, is that technical and scientific approaches, although important, are not sufficient for successful practice. In a series of classic case studies, Schön has revealed that technical knowledge alone is ineffective in negotiating the *indeterminate zones* of professional practice—those dimensions that fall outside of the realm of clear cut, black and white cases. In medicine, for instance, it is estimated that only about 15 percent of decisions are based on evidence alone (Gibbs, 1998, cited in DeCoteau, 2001), while the other 85 percent are "not in the book" (Schon, 1983, p.16). Thus, while professional education emphasizes evidence and technical information, a large percentage of cases do not respond to its application in practice. This overvaluing of technical and scientific approaches has been raised as a concern by a number of recent writers in the health professions (Barbour, 1995; Feinsten & Horowitz, 1997; Lown, 1996). A further irony is that although no one in the philosophy of science wants to be called a positivist any more (Schön, 1992), positivist approaches—themes of control, certainty, and measurable outcomes—often drive teaching, research, practice and policy in professional schools.

The pressure on practitioners to conform to dominant discourses in practice is further heightened by a "new managerialism" that poses a constant threat of external punitive surveillance. If practitioners fail to act according to professional dictates (often mandated by those removed from practice contexts), they face punitive actions (Davies, 2003; Grumet, 1988). This is operationalized through regulatory bodies and management structures that increasingly control practitioners' actions in the name of accountability, protection of the public, and efficiency. The resultant culture of fear erodes and constricts professional judgement (Davies, 2003), and creates barriers to the expression of the lived experience of the practitioner and to the enactment of engaged responsive relationships in professional life (Van Amburg, 1997).

Dominant discourses, steeped in the language of science and objectivity, can therefore present a conundrum for allied health practitioners. As discourses are inherently ideological, they involve a set of values and viewpoints in terms of which one must speak and act, at least while one is in the discourse; otherwise one doesn't count as being in it (Gee, 1991,1999). On the one hand, the adoption of dominant discourses places pressure on health practitioners to adopt approaches steeped in positivist conceptions and the language of instrumentalist theories, even when such discourses emerge from locations that are distant from their lived reality of practice.

On the other hand, many practitioners are aware that there are important and often untold stories that arise from what Schön (1983,1987) calls the 'swamp'; the messy, low ground of practice. Such stories are discerned through an epistemological position that begins with the experience of the practitioner, and an "inside-out" rather than an "outside-in" perspective (Hunt, 1987). This presents a challenge for practitioners because the stories about practice learned in health professional schools, and sanctioned by regulatory bodies, often fail to acknowledge practitioners' experience and the messy stories of practice.

Arthur Frank (1995) notes that ill persons tacitly agree to tell stories in medical terms that adopt the language of the medical profession and alienate them from their own voice. Yet, it is not only the ill person who makes such a tacit agreement, it is also the health practitioner. By telling 'professional' stories using the language legitimated by many health professions and learned in professional schools, other stories of practice are displaced and silenced. The narrative told from the perspective of the "medical gaze" (Frank, 1995) leaves little room for other stories that take place in the 'swamp' or that don't fit within the accepted discursive structure.

Compounding the influences imposed on practitioners who work within the parameters of dominant discursive structures, Argyris and Schon (1992) observe that practitioners tend not to communicate to one another, and perhaps not even to themselves, about their experiences:

> The community of professionals has tended to view learning about effective practice as a process that is private, tacit, and ephemeral. The professional practitioner tends not to communicate to his [her] peers—perhaps not even to himself [herself], in explicit terms—what he [she] learns about his [her] practice. It is uncommon for professionals to test their theories or to benefit from whatever degree of testing does occur; that is professionals often function without considering what they have learned from previous situations. (Argyris & Schön, 1992, p. 144)

In order to resist the hegemony of dominant stories, Frank (1997) argues that we have an individual and communal responsibility to articulate and communicate our own stories. Such stories may or may not have resonance within a particular community, but it is important that they be told. He notes that stories are told as claims to membership in communities, but the communities are not already there, waiting for the story. Rather communities are formed out of stories.

Critical discourse analysis: Making the familiar strange

Reflecting on what Schön refers to as the 'swamp' can raise insights that would guide behaviour in a manner that contradicts or resists the dominant discourse of a particular profession. This tension between the values of a

profession and the practitioner's *lifeworld* is a largely ignored and unarticulated dimension of professional life.

It has been recognized that control over discourse is a vital source of power, yet, also that there are limits to this control because meanings are fluid and can be reworked to resist domination (Wetherall, 2001). Choliaraki & Fairclough (1999) note for instance that alternative texts can challenge the hegemony and false closure of dominant discourses. While dominant texts exert power, such power is not uncontestable. As Wall (1995) points out:

> One of the most promising ways of looking at the relationship between knowledge structures and literary-discursive structures, it seems to me, is to see how certain types of texts…are able to imitate, reflect, contest, or even dismiss classical modes of knowledge acquisition and of knowledge transmission. These same complex structures can in turn refract, contest,
> or even dismiss the dominant power structures which we…read into them.

Critically reflecting on one's practice experience therefore, offers the possibility of unearthing untold stories and of potentially disrupting or challenging the hegemony of dominant discourses (Brookfield, 1995, 1998; Giroux, 1991).

Eisner (1998) defines criticism as "an art of saying useful things about complex and subtle objects and events so that others less sophisticated or sophisticated in different ways, can see and understand what they did not see and understand before" (p. 3). In general, the aim of criticism is to "illuminate a situation so that it can be seen or appreciated" (p. 7). To achieve this aim one must be able to use language to reveal what, paradoxically, words can never say. This means that the illusive quality of 'voice' must be heard in the text, and that relevant allusions and metaphors can be used to progress understanding (Eisner, 1998).

Drawing on Eisner's belief in the potential of the arts as a vehicle for revealing the social world, I suggest that reflecting on practice through poetic form, what I call *poetic resistance*, can be used as a mode of critical discourse analysis. The aim of such analysis is to raise questions about the link between theoretical and practical concerns within the public sphere of professional practice (Chouliaraki & Fairclough, 1999).

Poetic reflection

Using a poem inspired by my experience as an occupational therapist, I reflect on the manner in which adhering to a discourse of objectivity, can potentially silence experience rooted in the "life world", influence behaviour in practice, and create tension.

Educational philosopher John Dewey wrote many years ago that the "magic" of poetry is precisely "the revelation of meaning in the old ef-

fected by its presentation of the new" (p. 12). More recently, Willis (1999) has highlighted the merits of poetic reflection in that it gives a person free reign to ask in what way an episode of practice at a particular time spoke to the individual. This genre "gives room to move, to express feelings and ideas surrounding, and generated by, the phenomenon" (p. 107). Further it provides a medium through which the practitioner can represent and express reactions to, and interpretations of, experience (Willis, 1999).

Rebecca Luce Kapler (2003a), poet and educator, has argued for a reinvigoration of poetics in the curriculum. She believes that poetry can "touch the heart of what it means to be human" (p. 80) and give a shape and a hue to the vessel of consciousness. Furthermore she notes the potential of poetry to disrupt what we've taken for granted. She writes:

> Poetry can serve as interruption—it draws our attention to rhythms and then reinterprets them. The breath can stop when we least expect it, leaving us wondering before coming to understand. In that moment of silence and waiting, we may see differently, and sometimes uncomfortably. (Luce-Kapler, 2003b, p. 2)

Furthermore, the writing process itself offers the possibility of seeing differently. As Cixous (2001) points out "writing is precisely *the very possibility of change,* the space that can serve as a springboard for subversive thought, the precursory movement of a transformation of social and cultural structures" (p. 390).

This idea of "seeing differently" as a form of resistance, is one I'd like to consider through a poem. I composed this poem ten years after an event in professional practice to explore my lingering discomfort. It indeed caused me to see differently. During my third year working as a community-based occupational therapist, I met "Louise". Louise was 26 years old and she was living with a progressive brain tumor. She was a passionate, spirited woman, with a wicked sense of humor. At the time I was also 26 years old, and we developed a quick connection and easy rapport. Louise's tumor was inoperable, her prognosis was terminal, and her parents and teenage sister were committed to care for her at home. She experienced a rapid and painful deterioration in her condition over the course of her final year of life. As an occupational therapist, I worked with Louise intensively, and in a variety of ways. We identified how she would spend her final days, engaged in life review activities, laughed and cried, and planned for her goodbyes. As pieces of her life unfolded, I came to appreciate the intimate details, and indeed was a privileged witness to her story. Furthermore, I was an intimate witness to the failings of Louise's body, and the resultant army of changes to equipment, adaptations, and care routine interventions, as well as the brutal loss of privacy and independence that one cannot imagine until one has seen or lived it. During this time, I held a deep respect for Louise's family, whose love and anguish was worn openly. I felt a deep connection

to this family. When their son married and there was no one to stay with Louise—I stayed.

Prior to writing the following poem, I had been unable to find the words to express the conflict that I experienced as a health care practitioner in this situation. The poem represents an act of critical reflection (Brookfield, 2000) on a situation that left a lingering sense of discomfort. It provides an example of how "authoritative discourses" (Bakhtin, 1981)—in this case the discourses of "objectivism"—can exert control over the action and behaviour of a practitioner and pose a tension with the "personal" or "life world" (Husserl, 1999) realms that value relationship, emotion, feeling, care and love. I suggest that many practitioners experience tension of this nature day in and day out in professional settings, and that it is time that we take such tensions seriously in considerations that influence discussions about the design of health professional education, in the design of accountability mechanisms such as professional codes of ethics, regulatory standards, organizational demands, and in health care funding policies.

Professionalism

I was too professional
Louise
To give you the gift
A carefully picked out
remembrance

Of the hours we'd spent
planning your death

Negotiating the
painful intimacies
of the end of your life
Every other day
for a year

You—reminding me of me
Friendship blooming
where it should not
How unprofessional
to allow you to creep into
my heart!

You—my patient
not my friend

Your body's disappointments I know
of necessity
It is my job

I transgress by visiting
your family in the evening
on occasion
in emergencies

Your last Christmas
I keep the gift in my bottom drawer
guilty

You in your wheelchair
embarrassed to be seen by those
who knew you when you were beautiful
venture out with dark glasses, a scarf on your head, to buy
a treasure for me!

My professionalism
weighs heavily in my chest
as I ask your ghost for forgiveness

Resisting the dominant discourse

Adrienne Rich (2001) suggests that every real poem is the breaking of an existing silence, and the first question we might ask any poem is "what kind of voice is breaking silence, and what kind of silence is being broken?" (p. 150). The poem offered above is a resistance poem in that it speaks outside of the dominant discourse, and in this way resists the objectifying gaze within which many health professionals are trained to speak. Mattingly (1998), in her ethnography of health care practitioners juxtaposed what she refers to as "chart talk", the normative language of health care practice, with the "narrative talk" that she discovered many therapists adopt as an avenue for making sense of events in health care practice. Experiences that fall outside of the dominant ideologies that inform health professional practice, are typically silenced, or whispered in intimate gatherings with trusted colleagues. Enacting such stories opens an avenue for dialogue about the assumptions upon which health professional knowledge is legitimated and constructed.

For me, the poem enacted complex emotions that were not quite conscious prior to writing. My feelings of conflict about transgressing the notion of objectivity that I was taught in school, the deep emotional bond that I felt with Louise, and by seeing Louise and her family outside of work hours were revealed. The poem also manifested buried feelings of regret

for listening to the inner voice that I had constructed as "professionalism" and thereby not giving Louise the gift I had chosen for her. The gift—a small sculpture—stayed in the bottom drawer of my desk for a long time. It remains as a symbol to me of the deep privilege of witnessing Louise's journey, but also of the call to respond. For many years, I could not look at it without a tightening in my chest. I knew Louise over 15 years ago and I still think about her. Louise was mortified to be seen by those who knew her before her illness. She rarely left the house, despite encouragement from family, friends and therapists. She was embarrassed by drool, slurred speech, baldness, paralysis, incontinence. Yet, Louise ventured out in a wheelchair to purchase a gift for me—to receive it was one of the deeply moving encounters of my life. I regret in this instance that I did not respond.

In eight years of front line health professional practice, I frequently experienced an inner conflict with regard to my recognition that simply listening to a client's story with an open heart could be a profoundly healing act. Yet my professional role was cast along more "instrumentalist" lines that sought objective measures of what I accomplished with my clients, and an indication of my "accountability" and the "efficiency" of my interventions. To act according to these external pressures despite my recognition that much of what transpired in my practice as "healing" or "meaningful" occurred outside of the technical domain and could not be measured, created an inner tension. In a sense I was in a moral quandary. I was ethically bound to respond with accountability to the professional and organizational bodies that guided and legislated how I offered therapy services, to a professional culture that was increasingly concerned with outcome measures—measuring my time in 5 minute increments throughout the day, and to a regulatory body whose mandate was the protection of clients. At the same time I felt morally bound to respond to my internal moral code which called for an engaged response that wholeheartedly recognized and honoured the other.

The above poem is exploratory in the sense that it resists the usual professional language with respect to how one communicates about the experiences of health professional practice. In this regard it is presented as an example of the partiality, and situated nature (Haraway, 1991) of knowledge, and of ways of knowing that fall outside of the lines of professional discourses by beginning with the life world of the practitioner. Indeed, the sentiments reflected in the poem could be considered quite 'unprofessional', depending on one's interpretive stance and sympathies. Yet, such poetry illustrates part of the discomfort, frustration and tension that I and many other health professionals carry as a result of the professional rhetoric that we are socialized into, and to which we are accountable. And, the contrast that such language can pose to our undeniable emotions, perceptions and experiences as human beings—our "life world" dimensions—which must,

I speculate, frequently be disregarded or repressed, in order to successfully fulfill our perceived professional "obligations."

I recall once speaking to a physician who told me that she could not bare to reflect on her practice as it was too anxiety provoking. I wonder how many practitioners feel this way. And to what extent various practitioners feel they must repress or abandon their inner life world experience in order to meet perceived obligations in professional life?

The enactment of this poem has caused me to reflect on the relational dimensions of practice—relationship to myself and relationship to other—and the manner in which health professional curricula deal with such. The notion that one should be objective, autonomous, and devoid of emotion or attachment in professional relationships is a strong one. Yet, as Phillips explains "in our efforts to simplify, codify, categorize, control, explain, and diagnose, we fail to understand and care for each other" (p. 2). Held (1993) argues that our society is based on the ideal of the *autonomous man*, and would be more moral if it were replaced by the ideal of the *relational woman*. Indeed, Grumet (1988) has expressed surprise and outrage at what she refers to as the flagrant exclusion of female experience from the organization and life of educational environments, and from the theories and methods of learning and curriculum. I cannot help but wonder in what ways the notion of autonomous man has served as a template for our actions in the health and other helping professions, and how such an emphasis in health professional education influences practitioners' actions. I fear there are no simple answers here, but rather the beginning of many questions.

Conclusion

According to Davies (2003), "the first and necessary step in counteracting the force of any discourse, is to recognize its constitutive power, its capacity to become hegemonic" (p. 102). I suggest that insight gained through poetic reflection on practice can provide a means of questioning the closure imposed by dominant discourses. Furthermore it can foster conversations that raise questions and open a dialogue relevant to health professional education and practice, and that contributes to conversations that inform how educational programs in the health professions are designed. I call this approach to critical discourse analysis through poetic means *poetic resistance*.

Maxine Greene (1995) suggests that when we do human science we have to "relate ourselves to a social world that is polluted by something invisible and odorless, overhung by a sort of motionless cloud. It is the cloud of givenness, of what is considered 'natural' by those caught in the taken-for-granted, in the everydayness of things" (p. 47). Poetic reflection has the potential to reveal and perhaps see through such clouds—to offer a fresh vision, to begin a new conversation.

In proposing the possibilities of poetic reflection, I am not arguing for what Harvey (1993) has called a *vulgar situatedness*, as such a position can be viewed as just as deadly a trap as technical rationality (Wilson & Hayes, 2000). In either case we invoke singularities as the *sine qua non* of professional authority: "I am right because of science…I am right because of my experience" (Wilson & Hayes, 2000). Nor do I suggest that the insights gained through poetic reflection are univocal or non-problematic. Rather, I am proposing what Sandy Deluca (2000) has called *vigilant subjectivity*—an attention to one's own subjectivity in the interests of improving one's sensitivity to the 'Other', and one's capacity to act in the world. Poetic reflection is viewed as a way to enact lived realities and to bring them into conversation with others within a relevant community; to return us to the rough ground (Wittgenstein cited in Dunne, 1997), or the swamp (Schon, 1983, 1987)—to the insights garnered from living and acting in particular embodied worlds.

Further, I suggest attention to an epistemic reflexivity (Bourdieu, 1992) in which poetic reflection raises questions about the assumptions that underlie our disciplinary knowledges and fosters communication between practitioners about the discursive conventions that dominate the health professions. This paper seeks to resist the non-problematic adoption of a scientific discourse of objectivity by offering another way of seeing that considers the embodied life world and thereby draws attention to the partiality of perspective.

Gadamer (1992) asks: "In our society, which is increasingly ruled by anonymous mechanisms and where the word no longer creates direct communication …what power and what possibilities can the art of word, poetry, still have?" In reply, I wonder about the role of poetry as a vehicle to reveal stories about the lived reality of health care practice in professional life. I agree with Phillips (1994) when she writes: "Detached simplification in the service of manipulation is an effective strategy with inanimate objects; it is both ineffective and ethically unacceptable for encountering what is animate and endowed with meaning" (p. 3). How can poetry potentially awaken us and keep us attuned to ethically important moments in professional practice?

The poem in this paper represents a form of resistance to the dominant discourse by revealing a story based on the complexity of one practitioner's experience. This is a way of reading my private, embodied story in public (Sumara, 1996) in order to progress understanding of what I perceive as a broader social issue. This is an important form of resistance: "For when the literary imagination is invoked through historically-effected and situated interaction between reader and text, a world is brought forth by which perception is altered" (Sumara, 1996, p. 152). I have called this approach *poetic resistance*.

This critical analysis in no way claims to be authoritative, or exhaustive, or to offer solutions. As Luce-Kapler (2004) points out: "it is important to consider competing discourses and engage in debates without resorting to essentialism, binary division, or uncritical assimilation. Writing is … part of ever emerging cultural production that feeds back into society and contributes to its shaping" (p. 23). Therefore, this study aims, in the poetic sense that Maria Rainer Rilke (1984) would have it, to "live the questions." In a sense, it is an hermeneutic act that resists false closure. In the words of Jardine (1992), it is an effort toward the "restoring of life to its original ambiguity" (p. 116).

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